Adopted December 12, 1997 by the Managed Health Care Improvement Task Force

IMPROVING THE DISPUTE RESOLUTION PROCESS IN CALIFORNIA'S MANAGED CARE SYSTEM FINDINGS AND RECOMMENDATIONS

I. STATEMENT OF THE ISSUE

While managed care plans and their providers strive to prevent conflicts, disputes related to coverage, claims, medical necessity and other issues will be an inevitable part of any health care system. An efficient and effective dispute resolution process is an essential element of any health care delivery system and can play a crucial role in bolstering public confidence. It is especially important in managed care health plans[1] that use prior authorization as a method for controlling utilization. There is a wide perception and concern among consumers, advocates, providers, purchasers, and health plans that some disputes take too long to resolve, current processes are not well understood, disputes are not resolved efficiently, and information that could be gleaned from the process is not consistently used to improve either specific plans or the overall system.

II. ESSENTIAL ELEMENTS

An efficient and effective dispute resolution process must accomplish the following:

- Consumers need to be given the information and support necessary to understand their rights and responsibilities and the dispute resolution process and how to navigate it; they must not fear that exercising their rights would result in negative repercussions.
- When problems arise, efforts should be made to resolve them as quickly and as close to the point of service as possible.
- Some consumers will need assistance when they have problems, and assistance should be available, both from inside the health plan and externally.
- Formal processes must be fair, must treat like consumers alike, and must be perceived as fair by all parties in order to maintain support for the system; they must provide adequate opportunity for a full hearing, have consistent decisions, communicate findings to the consumer along with the basis for those findings, utilize qualified decision-makers, and reach decisions by applying the facts of the case using explicit standards.
- Formal processes must be efficient for consumers, providers, and plans, with severity of the issue recognized in timing and procedural standards.
- Formal processes must provide finality.
- Any process should both resolve individual issues and systematically provide information for quality improvement and monitoring.

III. CURRENT DISPUTE RESOLUTION PROCESSES

Currently, limited data exists relating to consumers' problems, the severity of those problems, and the relationship of problem experience to consumers' complaints and resolution. The Department of Corporations (DOC) is required to publish an annual report that provides data on complaints that come to the DOC through its toll-free hotline. In addition, Knox-Keene plans must report information about

[1] Throughout this paper, the term "health plans" refers to any health insurance arrangement or health benefits financial intermediary, unless otherwise specified (e.g., Knox-Keene regulated health plans).

complaints pending longer than 30 days. Two recent surveys conducted, one for the Task Force[2] and the other for three foundations[3], shed new light on consumer experience and problems. These surveys find from 27% to 42% of consumers have experienced problems with their health plan in the past year, and of those, approximately half contact their health plan. Surveys conducted by several large purchasers also provide some insight. One CalPERS-PBGH study found that of the 26% of members with a complaint or problem in 1995, 52% were dissatisfied with the way it was handled by their health plan.[4]

When a consumer has a complaint or grievance, his or her physician is often the most likely source of help and information. Beyond going to their physicians, the formal grievance process available to consumers varies greatly by sponsor/purchaser (e.g., individual, employer, Medicare, Medi-Cal), health plan, health plan product (e.g., HMOs, preferred provider organizations "PPOs", traditional, unmanaged, fee-for-service "indemnity"), and type and severity of grievance. In general, health plans' grievance and appeals processes include two levels of review within the plan. If members are dissatisfied with the result of internal processes, depending on their specific circumstances, many health plans require members to proceed to binding arbitration processes. Several laws require, and several accrediting and other organizations recommend, certain elements of the dispute resolution process. Besides the formal grievance process in health plans, there may be external grievance structures available to consumers that parallel or supplement these processes.[5]

IV. OBSERVATIONS ON HEALTH PLAN PRACTICES

Task Force staff and those Task Force members in the dispute resolution group examined health plans' current grievance processes, albeit not enough to draw firm conclusions, and found lack of consistency, ineffective communication, variable reporting, and some positive examples of use of complaint data for quality improvement.

V. RECOMMENDATIONS

From a consumer's perspective, whenever a plan denies a patient or his or her physician's request, he or she should be able to enter the grievance process (i.e., this is the point at which the patient receives information about the basis upon which a decision is made). This paper addresses issues related to the grievance process from the consumer's perspective. In addition, the paper makes some recommendations regarding utilization review because of the close link between utilization review decisions and adequate information for consumers to enter a formal grievance process.

A. Collaborative Development and Non-Duplication of Effort

1. Any of the recommendations below would benefit from a collaborative process in which the state entity(ies) for regulation of managed care,[6] health plans, purchasers, providers, consumer

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[2] Schauffler H, et al., "Public Perceptions and Experiences with Managed Care", conducted for the California Managed Health Care Improvement Task Force, 1997.

[3] Center for Health Care Rights, "Survey of Consumer Experiences in Managed Care", prepared for Kaiser Family Foundation, Sierra Health Foundations, and The California Wellness Foundation by The Lewin Group and Survey Methods Group, Inc., November 1997.

[4] Pacific Business Group on Health, *Health Plan Value Check*, 1996.

[5] For example, enrollees in Knox-Keene regulated plans may file a complaint with the DOC prior to binding arbitration or after binding arbitration, Health and Safety Code Section 1368(b)1B. Denials of care for Medicare enrollees must be systematically reviewed by an outside entity. Medi-Cal provides an administrative appeals process for denials.

[6] The term "state entity(ies) for regulation of managed care" refers to the DOC or the DOC and DOI or its/their successor.

advocates and other stakeholders[7] form a working group to develop the detailed terms of the proposal. In addition, many recommendations reflect existing law applied to specific populations (e.g., Medicare or Medicaid), to those health plans regulated by Knox-Keene, or standards privately developed (e.g., by accreditation bodies). Where requirements already exist, we recommend building on existing standards rather than creating completely new ones. Similarly, recommendations are intended to recognize and build on existing community resources.

B. Broad Application

2. The Task Force recommends that the recommendations in this paper apply broadly.

(a) The Task Force strongly encourages voluntary adoption and implementation of the recommendations and existing law and relevant accreditation standards by purchasers, employers, and plan administrators in those situations where ERISA preemptions restrict the regulation and oversight of health plan processes.

(b) The Task Force recommends that employers voluntarily include Task Force dispute resolution standards and those set forth in existing law and relevant accreditation standards in contract obligations for health plans.

(c) The Task Force recommends that the US Department of Labor, to the maximum extent feasible under federal law, amend its regulations, procedures and oversight pertaining to employer-sponsored ERISA health benefit plans to conform to (or, if not legally feasible, at least complement) California's implementation of Task Force dispute resolution recommendations and existing law and relevant accreditation standards. The state's entity for regulation of managed care should be directed to take the lead in consulting and coordinating with the US Department of Labor to facilitate this goal.

C. Consistency and Common Standards for Internal Plan Grievance and Appeals Processes

Individual consumers move among health plans and types of plans. Employers may change coverage, or consumers may move in and out of Medi-Cal, change jobs, get Medicare coverage, or select different individual coverage. Because of this fluidity, and because an essential element of all dispute resolution processes should be to treat like consumers alike, enrollees in all types of plans (HMOs, PPOs, POS, and indemnity) should have equivalent or consistent procedural rights and protections, regardless of type of plan or purchaser. While there may be greater perceived need for grievance processes in health plans with more selective networks and greater restrictions, consistency among dispute resolution processes would help all consumers. A consistent process would require consumers to learn only one basic system, and it would provide for better information and quality improvement. This would enable consumers to advocate more effectively for themselves, potentially improving satisfaction with results.

3. The Task Force recommends that consistent standards regarding dispute resolution processes for all health plans be developed and adopted, to the extent the power exists to do so. The development of these standards should include consultation with health plans, medical groups/IPAs, consumers, consumer advocates, regulators, and other stakeholders. The goal of these deliberations should be to establish mandatory complaint processes that encourage resolution

[7] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

as close to the point of service as possible, to structure balanced and efficient processes, and to elicit reporting that is comparable and equitable. Those standards should include (where they are not already required) the following:

(a) Application to Provider Groups. If a medical group/IPA or other provider organization provides services to a health plan's member or enrollee, the provider group should meet the statutory standards required of health plans, as required under current Knox-Keene law. For example, timing requirements would include complaint processing time at the medical group/IPA level.

(b) Timing Requirements. Turn-around time for resolving complaints at all levels of the dispute resolution process should be consistent, with time adjusted for severity of problem.

(1) Currently, Knox-Keene regulated health plans are required to resolve whenever possible and respond to non-urgent grievances within 30 days.[8,9] The Task Force recommends that all plans (e.g., including non-Knox-Keene plans) be required to resolve non-urgent complaints within 30 days, except under special circumstances (e.g., when complex medical issues need to be researched), when the time frame may be longer.

(2) Currently Knox-Keene regulated health plans must resolve or respond to urgent complaints (defined as a situation in which the standard time frame could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function as determined by a physician) within five days.[10] The state entity for regulation of managed care should examine this requirement and recommend (and provide rationale) to the Governor and the Legislature within two years as to whether all plans should be required to respond within 72 hours (as required by the Health Care Financing Administration) instead of the five days currently required.

(c) Periods of Limitation. Currently, Knox-Keene regulated health plans have an affirmative obligation to notify consumers of periods of limitations within which consumers must submit a grievance or appeal. These minimum periods of limitation should be standard across plans. The state's entity for regulation of managed care should establish minimum standards through a rulemaking. The ultimate minimum standard should include a provision for good cause exception. Periods of limitations should have no bearing on consumers' ability to access the state's entity for regulation of managed care for assistance.

(d) Communication of Processes. There should be consistency in how health plans inform consumers regarding how to use dispute resolution processes before and upon "grievable incidents." In addition, the state's entity(ies) for regulation of managed care, in consultation with health plans, should provide examples of well-prepared appeals for a variety of issues and make them available to consumers upon request.[11]

(e) Consumer Participation. Plans should provide opportunities for members to participate in the grievance process in person, at least at one time, to the extent possible.

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[8] Knox-Keene Act, Section 1368.01(a).

[9] Consumers enrolled in Knox-Keene regulated plans, after a 60-day period following submission of a grievance, are entitled to appeal to the Department of Corporations if their grievance remains unresolved at the plan level.

[10] Knox-Keene Act, Section 1368.01(b).

[11] The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.

(f) Full and Complete Explanations of Grievance or Appeals Decisions. If an in-plan physician's recommendation is denied by an organization (whether medical group or health plan), the physician should be notified and the patient should receive written notice, both of which should include the decision that was made, the reasons for the denial, the specific health plan contractual provision on which the decision is based (if applicable), the information that was reviewed in making the decision, any expert opinions or guidelines relied upon, and information and instructions on how to appeal the decision and timing.[12] Where explanations touch on quality of care issues, precautions should ensure that peer review processes are protected from intrusion.

(g) Terminology and Data Collection. The state entity(ies) for regulation of managed care should develop in collaboration with stakeholders, and phase-in with all deliberate speed, standard definitions to be used by health plans and the state entity(ies) for regulation of managed care for the meaning of terms commonly used in grievance processes, categories for reporting complaint types, and minimum standards for data collection by types of complaints.[13]

(h) Public Reports. Currently Knox-Keene plans must report complaints pending longer than 30 days, track their resolution, analyze the complaints, and use the information for quality improvement. In addition, after standard grievance terminology has been agreed (see recommendation 3.(g) above), the state entity(ies) for regulation of managed care should develop in collaboration with stakeholders and implement additional public reporting requirements (phased-in if necessary). Data reported to the state entity(ies) for regulation of managed care should be reliable and comparable, and the state entity(ies) for regulation of managed care should publish plan-specific and aggregate data on a periodic basis that should include data on all health plans. This data should be reported with the entity's(ies') own complaint and request for assistance data. In determining the amount and nature of the information to be reported, the state entity(ies) for regulation of managed care and stakeholders should consider, for example:

- aggregate numbers, types, length of time to resolution, and disposition of issues raised by condition or type of complaint, sorted by plan and medical group/IPA for groups over some size threshold (e.g., percent of enrollees, number of doctors, or top five groups per plan);
- a summary of the reasons decisions were upheld or overturned, including the basis upon which decisions are reached for particular types of complaints;[14] and
- the cost, comparability and validity of the data.

No such report should in any way impinge on patient confidentiality or peer review.

(i) Facilitate Consumer Contact With Regulators. The state entity(ies) for regulation of managed care should provide a single statewide "800" number that seamlessly transfers consumers to the appropriate agency.

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[12] When a Knox-Keene regulated health plan denies coverage for treatment, the plan must give the patient and provider the specific clinical criteria, if any, that was used in the denial (Section 1363.5).

[13] DOC has already developed common complaint categories for its hotline for the classification of types of complaints.

[14] The Task Force considered requiring plans to establish case-by-case precedents. While the Task Force believes that establishing consistency and making public the basis of health plan decisions, members think that requiring case-by-case precedents have limited applicability, could be overly burdensome on health plans, and potentially limit plans' discretion to resolve issues quickly and efficiently through compromise as close to the point of service as possible.

D. Consumer Empowerment

4. To be educated and empowered, consumers in all types of plans need full information on their rights and how to exercise them. Information should include a "bill of rights and responsibilities" received on enrollment, describing the complaint processes (as is required under current law for Knox-Keene plans). Also, when a denial or "grievable incident" occurs, appropriate information should be provided to the patient. In order to avoid increasing legalistic aspects of physician-patient relationships and to prevent increasing paper flow, current law should be reviewed to ensure the following standards exist for all consumers:

   (a) Health plans and medical groups/IPAs should direct members to the appropriate next steps at every stage where a member expresses disagreement with a provider or plan decision as well as provide adequate explanation of the patient's rights and the basis of the decision.[15]

   (b) If a patient disagrees with his or her doctor, the patient should be given at least oral notice, (not necessarily in writing), of the availability of, and access to, a second opinion and the grievance process. When the decision of the medical group/IPA or plan differs from that of the patient's physician, the patient should be given oral notice, or written notice upon request.

   (c) Health plans should be required to pay for second opinions from physicians within the consumer's health plan, and if there is no separate, qualified network provider, by a qualified out-of-network provider.

E. Consumer Assistance Through Plans

5. While the goal of the dispute resolution process should be to educate and empower consumers to be their own advocates, some consumers need assistance exercising their rights. Physicians can serve as important patient advocates. In addition, plans must have adequate internal systems and information to provide assistance. Such internal assistance may be particularly important for vulnerable populations. The Task Force recommends that private accreditation and quality audit standards, where applicable, should require plans to demonstrate support to consumers seeking to appeal, including coaching them on how to navigate the grievance process, adequate explanation of denial, and access to supporting documentation.

6. The Task Force encourages health plans to examine and adopt best practices as this will enhance member retention. Some exemplary efforts include the following:

   - seeking the opinion of outside specialists in the relevant medical specialty for issues related to medical necessity or experimental and investigational treatments; and
   - allowing members to attend reviews in person, or if the member can not (e.g., member is out of the area) or is not welcome to attend in person (e.g., member has a history of being abusive), by teleconference.

F. External Consumer Assistance

Because even the best health plan's or provider's internal processes will not be perfect, some consumers will also need an independent external resource to go to for information and assistance. In

[15] The Knox-Keene Act requires such notices at every stage.

addition, some consumers fear retribution from their provider or plan and are reluctant to pursue assistance from their employers. Currently, external resources exist (e.g., the DOC's toll-free hotline), but access to these resources varies greatly based on the individual consumer's circumstances. Appropriate activities performed by external resources may include developing and distributing educational material, providing referrals to existing resources, counseling, advising and assisting consumers on problem resolution at every stage in the process(except litigation), and dealing with plan and state regulatory entities.

7. (a) The Task Force recommends that two pilot, independent external assistance or external ombudsman programs in different regions of the state be authorized, for which state funding should be secured. Such pilot programs should be used to assess how best to serve all health care consumers, how best to inform consumers of the existence of such external assistance programs, how to use existing assistance resources most effectively, and how to educate consumers to use (but not overuse) services. The pilot projects should include an evaluation of the potential impact on premiums and the value of the services to individual consumers and the health care system relative to the costs. The pilot programs should be coordinated with the Sacramento-area independent assistance program (the Health Rights Hotline), and with existing, targeted health care assistance programs (such as the Health Insurance Counseling and Advocacy Program (HICAP), the Long-Term Care Ombudsman program, and the US Department of Labor's evolving efforts to assist enrollees in employer-sponsored ERISA plans). They should complement and not duplicate existing services provided by health plans, other existing external resources, or regulatory bodies. The pilot programs should have common data collection and evaluation systems and publicly shared data regarding complaints to identify systemic problems.

G. Independent Third Party Review

8. The state entity for regulation of managed care should be directed to establish and implement by January 1, 2000 an independent third-party review process that would provide consumers and health plans with an unbiased, expert-based review of grievances pertaining to delays, denials, or curtailment of care based on medical necessity, appropriateness, and all "experimental-investigational treatments."[16] The specific details should be developed through a collaborative process, which should consider the following issues:

   - whether access to independent review requires support of a provider in the consumer's health plan or any health professional;
   - what should be the standard for decisions, and what should be considered expert evidence;
   - how to ensure the decision-maker has adequate independence and appropriate expertise;
   - what, if any, access thresholds (e.g., internal process exhaustion requirements, financial or "merit," seriousness of a case as determined by external guidelines, nominal fees) should apply.

H. Arbitration Standards

9. Health plans should be required to establish arbitration standards that include the following:

[16] All Department of Insurance and Knox-Keene regulated health plans are required by AB 1663 to use an external review process for experimental treatments involving terminal conditions. California was a leader with this legislation.

(a) Arbitration systems used by plans should provide for expeditious resolution of disputes, including rapid selection, or default appointment, of neutral arbitrators. Judicial intervention should not be necessary to ensure the appointment of arbitrators.

(b) An arbitration award should be accompanied by a written opinion. Copies of written opinions (excluding personal and confidential, and patient and provider identifying information), including award amounts, should be available to the public upon request through the state entity(ies) for regulation of managed care.

(c) The state entity(ies) for regulation of managed care should be authorized to prohibit a plan from requiring a party to continue to participate in arbitration if the plan was found by the regulator to have engaged in willful misconduct in the proceeding.

I. Assessment

10. Health plans, providers, foundations, consumer groups, etc., should be encouraged to assess the efficacy of the full range of dispute resolution mechanisms including, but not limited to, non-binding arbitration, mediation, and neutral fact-finders. The use of such mechanisms should be linked to publicly disseminated independent evaluation of how well they meet the principles set forth in the list of "Essential Elements" above.